Hospital Stays Is Needed for Federal Health Programs

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-254131

September 17, 1993

The Honorable Daniel P. Moynihan
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

This is in response to your request that we report on the vulnerability of federal health programs to fraud and abuse by psychiatric hospitals. We initiated our work at the request of the former Chairman, whose concern stemmed from allegations that certain Texas psychiatric hospitals paid kickbacks for patient referrals; falsified diagnoses to obtain insurance payments; and detained patients against their will in order to maximize payments.

Specifically, we were asked to determine (1) whether federal health programs—Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)[1]—have been subjected to inappropriate practices by psychiatric hospitals to an extent comparable with the private sector and (2) whether federal programs have controls to protect their beneficiaries from such abuses. Appendix I provides a detailed description of our scope and methodology.

Results in Brief

Investigations to date have revealed that federal health programs have been subjected to fraudulent and abusive psychiatric hospital practices, but apparently to a lesser extent than private insurers. To date, the relatively small incidence of proven fraudulent and abusive practices has occurred primarily in private for-profit psychiatric hospitals. Investigators and health program officials believe that hospitals engaging in such practices have primarily taken advantage of people covered by private insurance, which has higher reimbursement rates for mental health services than federal programs and is thus more profitable for such hospitals. Many federal and state investigations are under way, which could identify further fraud and abuse in federal programs.

Federal programs have many controls in place to guard against unnecessary or poor quality care. However, some control weaknesses

[1]Medicare is a federal health insurance program covering most people aged 65 or over, and some disabled people. Medicaid is a medical assistance program for certain low-income people; it is jointly funded by the federal government and states and is administered by the states. CHAMPUS is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

exist that render federal programs vulnerable to fraudulent and abusive psychiatric hospital practices, resulting in some unnecessary hospital admissions, excessive lengths of stay, poor quality care, and unauthorized or duplicate payments. Moreover, some controls have not been fully implemented. For example, although required by federal law, some state Medicaid programs do not independently evaluate the need for inpatient care. In addition, while CHAMPUS reviews the medical necessity and quality of care of acute care psychiatric hospital admissions, it does not have adequate systems for ensuring that payments are limited to authorized psychiatric stays or to prevent duplicate payments.

Background

Federal health program costs for inpatient psychiatric care have increased substantially over the past several years. Combined costs for Medicare, Medicaid, and CHAMPUS increased 83 percent between fiscal years 1986 and 1991, from $2.9 billion to $5.3 billion. Medicare costs increased 87 percent, from $1.5 billion to $2.8 billion, during this period; Medicaid rose 82 percent, from $1.1 billion to $2 billion; and CHAMPUS climbed 96 percent, from $255 million to $500 million. In 1991, federal health programs paid for one-third of all private psychiatric hospital admissions. Most of the allegations of fraud and abuse leading to our review concerned private psychiatric hospitals. Benefits and payment methods vary for each program, as described in appendix II.

The involuntary hospitalization in April 1991 of a CHAMPUS beneficiary triggered investigations and concerns about psychiatric hospital practices. This case dramatically illustrates the type of abuse that has occurred. In 1991, Texas senate hearings exposed the story of a 14-year-old CHAMPUS beneficiary who was forcibly removed from his grandparents' home by two security firm officers and taken to a private, for-profit psychiatric hospital. His grandparents, having been shown a badge, believed that the two were police officers. The security officers were acting on orders of a psychiatrist, who it was later found had falsified his credentials. The psychiatrist had never seen the youth but believed him to be a substance abuser, based on statements by the youth's younger brother. Yet no drug test was conducted until the fourth day of hospitalization. When a test was administered, the results were negative. The grandparents, although legal guardians, were not allowed to see or speak with him in the hospital for almost a week. The assistance of a state senator and a court order was needed to get the youth released.

Federal Programs Appear to Have Been Affected to a Lesser Extent Than Private Insurers

The results of extensive investigations in Texas, as well as those from investigations by other states and federal departments, suggest that psychiatric hospitals engaging in fraudulent and abusive practices do not appear to have involved federal programs to the same extent as private insurers. That is, the number of alleged cases of fraud and abuse involving federal program beneficiaries is relatively small compared with that of private insurers. However, ongoing federal investigative efforts may identify further fraud and abuse in federal programs as these investigations conclude. One reason federal programs apparently have not been affected as much as private insurers is because of relatively low federal reimbursement rates. Federal programs may become more attractive revenue sources, however, as private insurers increasingly scrutinize the necessity of hospital admissions and stays.

The 1991 Texas senate hearings exposed many potentially fraudulent and abusive psychiatric treatment and billing practices. During some 80 hours of testimony, about 175 witnesses described their experiences with psychiatric hospitals. Most of the allegations were directed at private, for-profit psychiatric hospitals. Although most of the witnesses said they were covered by private insurance, some said they were federal program beneficiaries.

Among the allegations by witnesses in Texas were that hospitals (1) charged exorbitantly and billed for services never rendered; (2) engaged in overly aggressive and deceptive advertising and marketing; (3) paid kickbacks or bounties for delivering patients to treatment facilities; (4) held voluntary patients against their will without medical justification; (5) unnecessarily hospitalized patients whose conditions could have been treated in less restrictive settings; (6) discharged patients, regardless of their condition, once their insurance benefits were exhausted; (7) used questionable and potentially abusive therapy; (8) used excessive medication; and (9) isolated patients from family and friends by withholding visitation, phone, and mail privileges.

Federal and state organizations are investigating similar abuses in psychiatric hospitals throughout the country. Investigations directed primarily at federal health programs are under way by the Department of Health and Human Services' (HHS) Inspector General (IG), the Department of Defense's (DOD) Criminal Investigative Service, and the Federal Bureau of Investigation. At the state level, investigations are under way in several states including those by the Florida and New Jersey departments of insurance. As in Texas, these federal and state investigations are finding

that abusive and fraudulent practices are primarily directed at private insurers as evidenced by the small number of cases involving federal beneficiaries. Details on these and other investigations are in appendix III.

Some investigations have resulted in settlements. However, most had not been concluded at the time of our review. For example, the Texas Attorney General had reached settlements of $12.8 million with four psychiatric hospital chains. Although the hospitals did not admit guilt, the settlements included the hospitals' agreement to cease certain practices such as paying for patient referrals.

Hospitals that use fraudulent and abusive practices appear to have primarily targeted private insurers because it is more profitable. Many federal and state officials told us that Medicare and Medicaid's lower reimbursement rates have made these programs less attractive than private insurance. While private insurers often pay 100 percent of psychiatric hospitals' billed charges, the federal programs pay less. Of the three federal programs, CHAMPUS payments are highest, with Medicare next, and Medicaid the lowest. For example, the average daily allowed amount to four private psychiatric hospitals we studied was $839 by private insurers, $505 by CHAMPUS, $480 by Medicare, and $298 by Medicaid.[2]

Federal and state health officials believe, however, that federal programs may be affected more in the future as some psychiatric hospitals look for additional revenue sources. These officials stated that because of the adverse publicity that psychiatric hospitals have received, as well as increased scrutiny by insurance companies, some hospital occupancy rates are down, placing pressure on them to generate more revenue.

Federal Health Programs Have Many Controls, but Some Weaknesses Exist

Although federal health programs have many controls to protect against psychiatric hospital fraud and abuse, some control weaknesses exist. Existing controls include utilization reviews, audits of hospital cost reports, facility inspections, and complaint investigations. However, weaknesses also exist such as inadequate attention to findings stemming from Medicare reviews of hospital stays at for-profit psychiatric hospitals, insufficient attention to states' certification that youths need inpatient psychiatric care under Medicaid, limited CHAMPUS follow-up to determine if

[2]We selected two Florida, one Texas, and one New Jersey psychiatric hospital for our comparison. Only New Jersey paid for care in psychiatric hospitals for Medicaid patients and, consequently, we limited our Medicaid comparison to this one hospital.

problems found in psychiatric hospitals have been corrected, and inadequate CHAMPUS payment controls.

Controls Established to Help Protect Federal Programs From Fraud and Abuse

The three federal health programs have a variety of controls in place to guard against fraud and abuse. These controls include utilization reviews, audits of hospital cost reports, facility inspections, and complaint investigations.

Medicare performs utilization review on a retrospective basis (that is, by examining a sample of records of patients after they have been discharged from hospitals). When a review indicates the existence of problems at a particular hospital, 100 percent of the Medicare discharges from that hospital are reviewed (referred to as an intensified review). For psychiatric hospitals, intensified reviews are conducted if, during a 3-month period, 5 percent of cases are denied (with a minimum of six cases). Generally, to be Medicare-certified, a psychiatric hospital must not only be accredited by the Joint Commission on Accreditation of Healthcare Organizations, but also pass annual inspections of their staffing and medical records. As another control, complaints about Medicare-certified hospitals are investigated, often on-site, regardless of whether they involve Medicare beneficiaries. Complaint investigation results can trigger an intensified review. Medicare also has payment controls, including audits of hospital cost reports and limits on increases in costs.

Medicaid requires states to perform utilization reviews. States can use one or more types of utilization reviews: preadmission reviews to determine the medical necessity of admissions, concurrent reviews to determine the medical necessity of continued stays, and retrospective reviews to determine the quality of care and medical necessity. In addition to utilization reviews, Medicaid has a variety of payment controls.

CHAMPUS requires preadmission, concurrent, and retrospective utilization reviews. Additionally, CHAMPUS requires on-site inspections of residential treatment centers to determine their compliance with CHAMPUS requirements. Finally, CHAMPUS too has several payment controls, such as annual limits on rate increases and checks to ensure that paid days do not exceed benefit limits.

Inadequate Attention Given to Medicare Review Findings at Psychiatric Hospitals

Although Medicare's intensified reviews of patient care at a limited number of Texas hospitals revealed many problems, the Health Care Financing Administration (HCFA) has not required, on a nationwide basis, additional intensified reviews of private, for-profit psychiatric hospitals' practices. For example, based on a complaint, Medicare performed an intensified review of a for-profit psychiatric hospital in Texas. The review identified problems and therefore Medicare performed intensified reviews of four other Texas psychiatric hospitals operated by the same hospital chain. As shown in table 1, these reviews identified unnecessary care and problems with the quality of care in all but one of the hospitals.

Table 1: Results of Intensified Reviews in Five Texas Hospitals (10/01/90-09/30/91)

	Review results		
Hospital	Number of cases reviewed	Percent of cases with days denied[a]	Percent of cases with quality problems
A	156	28	13
B	251	16	3
C	152	8	4
D	13	0	0
E	124	22	4

[a]Represents the percentage of patient cases where all or part of the care provided was determined by Medicare to be medically unnecessary and, therefore, payment was denied for the unnecessary days of care.

HCFA, however, has not required that intensified reviews be conducted on other private, for-profit psychiatric hospitals. Instead, it is relying on its standard reviews and complaints to identify the need for intensified reviews.

Insufficient Attention Given to States' Certification That Youths Need Inpatient Psychiatric Care Under Medicaid

To protect youths from unnecessary and inappropriate hospitalizations, Medicaid requires states to certify the need for inpatient psychiatric care for youths. Yet IG and Medicaid state agency reviews have found problems in states' compliance with the requirements. Although HCFA is responsible for ensuring states' compliance with the certification requirements, the review findings indicate that HCFA has paid insufficient attention to states' certifications.

To meet Medicaid's congressionally mandated requirements, states are to certify that (1) less intensified treatment is not available to meet the youths' needs, (2) inpatient treatment under the direction of a physician is

needed, and (3) services can reasonably be expected to improve the youths' condition or to prevent further regression so that treatment will no longer be needed. Except in emergency cases, this certification must be made by an independent team that includes a physician competent in diagnosing and treating mental illness and knowledgeable of the individual's situation.

An HHS IG report stated that HCFA has placed insufficient emphasis on states' certification. The IG reported in 1990 that it found noncompliance with Medicaid's certification requirements in all five states reviewed: Arkansas, Louisiana, Missouri, New York, and North Carolina. The review found, among other things, that some state Medicaid agencies did not require certifications and that other states that required certification allowed them to be made by hospital physicians rather than by independent teams. Additionally, the review found that HCFA regional offices have not, for the most part, identified and addressed this noncompliance problem.

This IG review concentrated on states' compliance with the documentary requirements. However, in a related review in Louisiana and Oklahoma, the IG went beyond the documentary requirements and had a clinical child psychiatrist determine whether hospitalizations were actually needed, under Medicaid requirements. The psychiatrist, having reviewed medical records of 100 Medicaid recipients in each state, found many cases of inappropriate care. Specifically, about 25 percent of the Oklahoma patients and about 32 percent of the Louisiana patients did not need inpatient care or did not meet the Medicaid requirements for inpatient psychiatric care. The IG is considering expanding to other states its efforts to determine whether youths have been hospitalized inappropriately. The IG has requested HCFA's assistance in funding this effort.

In addition to the IG reviews, recent Medicaid reviews by state medical personnel found similar problems in three New Jersey private psychiatric hospitals.[3] Among these problems were (1) certifications often were not made by a team, (2) the certifying team was from the hospital rather than independent, (3) the team did not include a physician, and (4) documentation was sometimes vague concerning the patients' need for inpatient treatment under the direction of a physician.

[3]New Jersey was the only one of the three states we visited that was subject to the certification requirements.

Limited CHAMPUS Follow-up on Problems Found in Psychiatric Hospitals

Although CHAMPUS utilization reviews and complaint investigations have identified problems, CHAMPUS has thus far not systematically followed up with psychiatric hospitals to determine whether problems have been corrected. Until recently CHAMPUS had no procedures for notifying the hospitals of the problems detected, for specifying the corrective actions to be taken, or for recouping funds, if necessary. As we have previously reported,[4] CHAMPUS preauthorizes psychiatric hospital admissions, concurrently reviews hospital stays, and regularly reviews cases retrospectively. It has identified questionable admissions as well as quality of care issues. For example, in about half of the retrospective review cases, documentation in the medical record did not substantiate the medical necessity of the entire stay. As for quality-of-care issues, medical records in some cases described patients as suicidal but did not indicate that any precautions were taken. In other cases, patients' safety may have been compromised because of questionable medication dosages or practices.

In March 1993, the Acting Assistant Secretary of Defense (Health Affairs) informed us that DOD had decided to take several actions regarding these findings and future retrospective reviews. DOD will

- notify hospitals of problems detected and plans to closely scrutinize them in the future,
- refer to the IG those cases where a provider misrepresented information, and
- retrospectively deny reimbursement for care found to be medically unnecessary or inappropriate.

Also, DOD is about to award a contract to (1) monitor the quality and appropriateness of mental health services provided to CHAMPUS beneficiaries and (2) research and develop mental health standards of care.

DOD officials stated that DOD does not anticipate surveying or inspecting psychiatric hospitals as a routine means of following up on identified problems. They said, however, that CHAMPUS currently has the authority to make such visits and if necessary would do so. Officials also told us they sometimes try to resolve complaints and other problems by letter or telephone rather than by inspecting the facility involved.

[4]Defense Health Care: Additional Improvements Needed in CHAMPUS's Mental Health Program (GAO/HRD-93-34, May 6,1993); DOD Mental Health Review Efforts (GAO/HRD-93-19R, Mar. 31, 1993); and Defense Health Care: Efforts to Manage Mental Health Care Benefits to CHAMPUS Beneficiaries (GAO/T-HRD-92-27, Apr. 28, 1992).

CHAMPUS Controls Over Payments for Psychiatric Services Are Inadequate

CHAMPUS has not ensured that adequate controls are in place over payments for psychiatric services. CHAMPUS uses contractors (that is, insurance companies) to process and pay beneficiaries' medical care claims. However, these contractors have not established adequate systems to (1) ensure that payments are limited to authorized psychiatric stays or (2) prevent duplicate payments.

CHAMPUS's mental health utilization reviewer provides the contractors with the dates of hospital stays it has authorized, and the contractors are to limit payments to these dates. However, a CHAMPUS analysis of stays in residential treatment centers showed that the contractors had frequently paid for care beyond the authorized days. The utilization reviewer and the contractors recently researched about 1,500 residential treatment center claims suspected of containing potential payment errors of this type. The research showed that as many as half the claims had been overpaid.

While this payment problem occurred with all three of CHAMPUS's contractors, it was especially serious at one. This contractor's automated system did not match the dates on claims with the utilization reviewer's authorization dates. As the contractors that process and pay residential treatment center claims are the same ones that process and pay psychiatric hospital claims, using the same systems and the same methods, it seems likely that the problem extends to psychiatric hospital claims.

In addition to the problem of not limiting payments to authorized dates of care, the contractors' automated systems do not prevent duplicate payments. The above-mentioned research of residential treatment stays identified 191 duplicate payments. For these payments, a CHAMPUS official informed us, in March 1993, that it was in the process of recouping $2.6 million. In addition, the contractors have independently identified and begun recoupment of another $1.4 million in duplicate payments. Because the fiscal intermediaries use the same automated systems to pay all CHAMPUS claims, the duplicate payment problem likely extends beyond residential treatment center payments.

Conclusions

Investigations to date have revealed that federal health programs have been subjected to fraudulent and abusive psychiatric hospital practices, but apparently to a lesser extent than private insurers. Lower reimbursement rates and greater controls have made federal programs less vulnerable to such abuses. Federal investigations, however, as they conclude, may identify further fraud and abuse in federal programs.

Some federal control weaknesses do exist that have resulted in unnecessary hospital admissions, excessive stays, and sometimes inadequate quality of care. HCFA's intensified reviews of five psychiatric hospitals found these problems occurring in Medicare, which, in our view, indicates a need to determine if similar problems exist elsewhere by conducting intensive reviews at other hospitals. Also, HCFA has paid insufficient attention to some states' noncompliance with requirements to certify the need for inpatient care under Medicaid.

DOD has also identified numerous instances of quality problems and unnecessary hospital admissions. In our view DOD scrutinizes the provision of mental health services to beneficiaries more thoroughly than other federally financed insurance programs. Also, we believe DOD has made an appropriate commitment to take action against providers who deliver unnecessary or inappropriate care and to track these facilities' future performance. In order to track a facility's performance, however, DOD may need to selectively visit and inspect hospitals to determine if problems were corrected. Lastly, DOD needs to establish better controls to ensure payments are made only for authorized care and to avoid duplicate payments.

Recommendations

We recommend that the Administrator of HCFA

- require intensified reviews under Medicare, on a selective basis, of for-profit psychiatric hospitals to determine whether problems exist with unnecessary hospital stays and quality of care; and
- increase oversight and enforcement of Medicaid certification requirements that youths need inpatient psychiatric care, and if the Administrator believes that existing authority does not permit doing so, ask the Congress to amend the law.

We further recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to

adopt procedures for selectively visiting and inspecting psychiatric hospitals to determine whether problems involving unnecessary hospital stays and quality of care have been corrected; and

- ensure that the contractors improve their claims payment systems to minimize payments for unauthorized hospital stays and to avoid duplicate payments.

Agency Comments

We obtained written comments from HCFA on a draft of this report. (See app. IV.) Although HCFA said it had no objections to our recommendations to the Administrator, it expressed concerns about each one. Regarding the recommendation to require intensified reviews of for-profit hospitals, HCFA said that it was redirecting its review program from using individual case reviews to using profile analysis as the means of identifying problem areas. Thus, it did not believe that for-profit psychiatric hospitals should be targeted for intensified or focused review unless utilization and quality concerns were identified using the profiling approach. We disagree, and note that HCFA's own findings in Texas as well as other government and private program investigations (which are detailed in app. III), have clearly illustrated that problems already exist with for-profit psychiatric hospitals. Therefore, we continue to believe that HCFA should selectively require intensified reviews of these hospitals.

Regarding our recommendation to increase oversight and enforcement of Medicaid certification requirements of youths' need for inpatient psychiatric care, HCFA said that it lacks authority to look behind the substance or accuracy of states' determinations in this area and a statutory change would be necessary to implement the recommendation. HCFA was referring to its authority under section 1903(g) of the Social Security Act that relates to penalizing states that fail to meet federal requirements for utilization and medical review programs for institutional services. Although our recommendation was not intended to refer specifically to the section 1903(g) penalty provision, we question HCFA's narrow reading of section 1903(g), which charges HHS with ensuring that each state "has an effective program of medical review of the care of patients in mental hospitals."

We also note that HHS has other authorities under the act for preventing unnecessary or inappropriate care. For example, under section 1902(a)(30), states must follow procedures "necessary to safeguard against unnecessary utilization of services." HCFA can use its general authority for monitoring state operations to enforce those state procedures. In addition, HCFA has authority at section 1902(a)(33) to independently validate state determinations that institutional providers, including psychiatric hospitals, are suitable to participate in Medicaid. Validation could involve ascertaining if these facilities provide only necessary and appropriate care to Medicaid beneficiaries.

In any event, HCFA has not disagreed with the substance of our recommendation that it increase its oversight and enforcement of

certification requirements in this area. We have modified the recommendation to urge HCFA, if it continues to believe that it lacks statutory authority to carry out this recommendation, to ask the Congress to give it such authority.

HCFA also said that it would have its regional offices advise states of the need for increased emphasis on overseeing the propriety of institutional placement of youths, quality of care, and need for continued stays. HCFA said that it was considering including these areas in its 1994 reviews of states and that it was working on a regulatory revision to better define psychiatric benefits under Medicaid. These plans, if implemented, should help improve state operations related to psychiatric care for youths.

We also discussed a draft of this report with DOD officials. They generally agreed with the findings and recommendations. CHAMPUS has taken steps and is planning a number of other efforts to improve the accuracy of its claims payments, namely:

- electronically transmitting mental health authorizations to contractors responsible for paying claims,
- establishing a patient authorization file to verify contractor payment records,
- conducting on-site compliance reviews of contractors focusing on mental health authorization requirements, and
- revising its computer programs for the detection of potential duplicate payments.

We are sending copies of this report to the Secretary of Defense and the Administrator of HCFA and interested congressional committees. We will make copies available to others on request.

Please contact me at (202) 512-7101 if you or your staff have any questions. Major contributors to this report are listed in appendix V.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

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Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IG	Inspector General
PRO	peer review organization

Scope and Methodology

To obtain information on psychiatric hospital activities for Medicare and Medicaid, we interviewed officials and reviewed documents at the Health Care Financing Administration headquarters and at its regional offices in Atlanta, Dallas, Denver, and New York. We telephoned HCFA officials in the remaining regional offices to obtain information. To obtain information on the Civilian Health and Medical Program of the Uniformed Services, we conducted interviews and obtained documentation at the Office of CHAMPUS, in Aurora, Colorado, and at the CHAMPUS national mental health utilization review contractor, Health Management Strategies International, in Alexandria, Virginia. We also contacted several Medicare and CHAMPUS contractors (fiscal intermediaries) to determine whether problems had been detected with psychiatric hospital billings.

To obtain a national perspective on psychiatric hospital investigations, we interviewed officials of the Departments of Justice, Health and Human Services' Office of the Inspector General, Defense's Criminal Investigative Service, and the National Health Care Anti-Fraud Association.

We also conducted work in Texas, Florida, and New Jersey. These states were selected from among those where abuses were reported and active investigations of psychiatric hospitals were under way. In each of the states visited, we interviewed officials and reviewed documents at the state agencies responsible for regulating psychiatric hospitals. In addition, in these states, we contacted the state attorney general's office and the Department of Insurance. In Texas and New Jersey, we also performed work at the Medicare peer review organizations (PRO); at the time of our visit to Florida, the PRO had been replaced and the new one had not yet begun its Medicare psychiatric case reviews. Additionally, in Texas, we reviewed hearing records and reports.

In doing our work, we

- reviewed laws, regulations, policies, and procedures pertaining to the Medicare, Medicaid, and CHAMPUS psychiatric hospital programs;
- obtained and analyzed psychiatric hospital utilization and cost data for the three federally funded health programs;
- obtained information on reported instances of psychiatric hospital fraud and abuse and determined whether there was federal health program involvement;
- reviewed findings on complaint investigations by Texas state agencies;
- compared rates of reimbursement to psychiatric hospitals by private insurance companies with those by federal health programs; and

- randomly sampled cases from a special CHAMPUS project on residential treatment center stays in order to determine the causes of payment discrepancies.

We did our work between March 1992 and March 1993 in accordance with generally accepted government auditing standards.

Medicare, Medicaid, and CHAMPUS Inpatient Psychiatric Benefits and Payment Methods

Program	Benefits	Payment method
Medicare	In a psychiatric hospital: 190-day lifetime limitation In a general hospital (including a distinct psychiatric unit of a general hospital): No lifetime limitation	Psychiatric hospitals and distinct units of general hospitals use a cost-based payment method on the basis of reports filed annually by each hospital General hospitals use a prospective payment method on the basis of diagnosis-related groups
Medicaid	In a psychiatric hospital: Ages 21-64: Not authorized Under age 21 and over age 64: state option[a] Except for a few states, there are no limits on the number of days allowed In a general hospital (including a distinct psychiatric unit of a general hospital): Available for all ages Except for a few states, there are no limits on the number of days allowed	Method varies: most states use a type of prospective payment method (on the basis of diagnosis-related groups or on negotiated rates); a few states use a cost-based method
CHAMPUS	In a psychiatric hospital (or a distinct psychiatric unit of a general hospital): Adults: 30 days per year Children: 45 days per year Waivers may be granted to increase the days authorized In a general hospital: Same limits as in a psychiatric hospital Residential treatment center: Available to children 150 days per year Waivers may be granted to increase the days authorized	Psychiatric hospitals, distinct psychiatric units of general hospitals, and residential treatment centers use per diem rates (on the basis of charges billed by each type of facility) General hospitals use a prospective payment method on the basis of diagnosis-related groups

[a]States can select either or both options. In 1992, 39 states had selected the "under age 21" option; 40 had selected the "over age 64" option. Under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program, however, all states must periodically screen all eligible children to identify and treat any medical condition, including psychiatric conditions.

Many Investigations of Psychiatric Hospitals Are Under Way

Federal and state agencies are investigating psychiatric hospitals in a number of states. Some investigations have resulted in settlements with the hospitals, but most had not been concluded at the time of our work.

As of March 1993, the Department of Health and Human Services' Inspector General was participating in state investigations as well as conducting its own. In Wisconsin, for example, the IG was working with the state Attorney General's office in investigating allegations that a hospital was defrauding Medicaid as well as private insurers. The hospital was allegedly paying kickbacks for patient referrals; billing for services not provided, including days during which patients were not hospitalized; and basing patients' lengths of stay on the amount of insurance coverage available instead of their need for care. In Georgia, the IG had completed an investigation that resulted in the indictment of a psychiatric hospital chain's vice president for filing false Medicare hospital cost reports. The chain settled the case for $2.4 million.

Other federal agencies are investigating psychiatric hospitals. The Department of Defense's Criminal Investigative Service, which is investigating several psychiatric hospitals throughout the country, was unwilling to provide details about these ongoing investigations. However, officials said that one case was nearing completion, with either a plea bargain or an indictment expected. Also, they said that one investigation had already resulted in the indictment of a psychiatrist and was being expanded to the psychiatric hospital he was associated with.

According to several sources, the Federal Bureau of Investigation is investigating psychiatric hospital fraud. Florida, New Jersey, and Texas reportedly are included in these investigations. However, the Department of Justice would neither confirm nor deny the Bureau's investigative involvement.

States are also conducting investigations. For example, both the Florida and New Jersey Departments of Insurance were conducting investigations at the time of our review but were unwilling to discuss details because the investigations were ongoing. As the result of an earlier investigation, the New Jersey Department of Insurance had settled with one for-profit psychiatric hospital on allegations of fraudulent billings for $400,000.

Following an investigation that began in 1991, the Texas Attorney General reached settlements with four psychiatric hospital chains. Although none of the chains admitted guilt, the settlements totaled $12.8 million and

contained provisions prohibiting the hospital chains from engaging in certain practices in Texas. For example, in one settlement the chain agreed not to engage in a wide range of marketing and admission practices, such as placing paid referral representatives in Texas public schools, giving employees incentives for fulfilling patient quotas, and admitting patients who had not been evaluated by a licensed psychiatrist in the preceding 72 hours. In addition, the hospital chain agreed to a settlement of approximately $9 million; this amount included waiving payment of claims, reimbursing investigative costs, and providing charitable mental health services.

Other investigative activities include those of nationwide health care task forces consisting of members of various federal and state agencies. We were told that these task forces are beginning to see trends of nationwide psychiatric fraud, including upcoding, double billing, billing for therapy that should be included in per diem payments, and billing for individual therapy that was actually group therapy.

In addition to federal and state investigations, 10 large insurance companies have brought lawsuits against a hospital chain under the Racketeer Influenced and Corrupt Organizations Act. The first lawsuit, filed in July 1992 by eight insurance companies, claims that the chain hospitalized patients who did not need hospitalization and charged for treatment, services, and supplies that were either unnecessary, not provided, or provided at grossly inflated levels. The second lawsuit, filed in September 1992 by two insurance companies, charges that the chain, among other things, paid kickbacks for referrals and kept patients in the hospital, regardless of medical need, until their insurance coverage was exhausted. As of March 1993, both lawsuits were pending.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date MAY 20 1993

From William Toby, Jr.
Acting Administrator

Subject General Accounting Office (GAO) Draft Report, "Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays is Needed to Lessen Federal Health Program Vulnerability" -- INFORMATION

To Director of Federal Health Care
Delivery Issues
Human Resources Division, GAO

We have reviewed the subject report and have no objections to the issues raised by GAO and its related recommendations for improvement. However, we would like to point out that considerable resources have been expended in establishing controls and fostering their use in an attempt to: prevent improper hospitalization of children; improve quality of care for those that are placed in institutional settings; and, limit the expenditure of Federal funds for only those services that will benefit patients and assure their movement back into the mainstream of society.

During the late 1980s and in 1990, the Health Care Financing Administration (HCFA) and the Department of Health and Human Services' Office of Inspector General (OIG) worked together to perform a significant number of audits of youth inpatient psychiatric care, acted aggressively to correct the deficiencies found, and recovered Federal Medicaid funds which had been inappropriately claimed by the States. The recovery of Federal funds resulted in many protests from the States. Congress, through the Omnibus Budget and Reconciliation Act of 1990 (OBRA 90), placed limitations on HCFA that effectively precluded any disallowance actions for periods prior to November 5, 1990. As a result, related disallowances that had been issued for the pre-November 5 period were withdrawn.

However, OBRA 90 did not prevent HCFA from prospectively enforcing the program's requirements after November 5. On November 30, 1990, HCFA informed the State Medicaid agencies that HCFA would strongly enforce the program's requirements. Since that time, we have worked with the States' agencies and the OIG in overseeing the States' implementation of this program to assure that the program's intent and regulatory requirements are effectively and efficiently carried out.

Our comments on GAO's specific recommendations follow.

GAO Recommendation

We recommend that the Administrator of HCFA:

-- require intensified reviews under Medicare, on a selective basis, of for-profit psychiatric hospitals to determine whether problems exist with unnecessary hospital stays and quality of care;

HCFA Comment

Under previous contracts, the Peer Review Organizations (PROs) have performed intensified review for both utilization and quality problems for all providers, including for-profit psychiatric facilities. Intensified review was performed whenever HCFA-prescribed thresholds had been exceeded. The review was continued until the problem had been corrected. Under this methodology, periods of intensified review could be quite lengthy without correcting the underlying problem.

Under the next PRO contracts, which began implementation April 1, 1993, and will all be awarded by October 1, 1993, the PROs will identify areas of concern through extensive data analysis (including data from case review) and will work with providers and practitioners to improve their performances (improvement projects). As part of the data analysis process, the PROs may perform a focused review to further study a quality or utilization concern, or to monitor a provider's/physician's performance under an improvement project. A focused review will address specific issues (e.g., why a particular hospital has a longer length of stay for a specific diagnosis than other similar hospitals in the State) and will be strictly limited in duration. This strategy will place emphasis on the improvement of performance, rather than on long periods of intensified case review.

We do not believe that PROs should automatically conduct focused review of for-profit providers. If the PROs find utilization and quality concerns among for-profit providers, then it will be appropriate for PROs to target their review efforts to those providers.

In addition, we are currently in the process of organizing a workgroup to study this issue as it relates to the hospitals reviewed in this report. This workgroup will consist of staff from HCFA, intermediaries and carriers, the PROs, as well as, the OIG. The workgroup will also investigate potential abusive practices in other hospitals for which Medicare makes payment.

GAO Recommendation

-- increase oversight and enforcement of Medicaid certification requirements that youths need inpatient psychiatric care.

HCFA Comment

Certification of the level of care under the Psych Under 21 benefit falls statutorily under the authority of the States. HCFA has no authority to look behind the substance or accuracy of the State's determination in these matters. Rather, our authority is limited to assuring that the State's inspection of care process was completed for 100 percent of the Medicaid patients for whom payment was claimed, by appropriately constituted review teams, and in a timely matter. Without a statutory change, the GAO recommendation would not be able to be implemented.

We will, however, ask the regional offices (ROs) to advise the States of the need for increased emphasis on overseeing the propriety of institutional placement of youths, the quality of care provided, and the ongoing evaluation of patients' continuing need for inpatient psychiatric care.

Furthermore, in our upcoming Fiscal Year 1994 Financial Management work planning process we will consider including this subject for review by the ROs. Doing these audits will depend upon the availability of funds for contractors to perform the necessary onsite reviews of patient placement and quality of care.

Additionally, we are attempting to address these problems by improving the certification of need procedures in a regulatory revision, and also by more carefully defining the settings that may be used for this benefit. Also, in a separate effort, we are attempting to preclude Medicaid expenditures for services which should be provided by juvenile and other justice authorities.

Other Matter

Now on p. 6.

With regard to the Texas study mentioned on page 10, we have the following comment:

The Boston RO has advised HCFA of a potential concern involving a for-profit psychiatric hospital chain and the possible billing for unwarranted psychiatric hospital stays and for treatments that were either not provided or that were provided without medical justification. As a result, HCFA has requested that PROs performing case

review at facilities in the identified chain, compile specific information from completed case reviews (including the Texas hospital study). HCFA is currently collecting and analyzing the PRO review data to determine whether a problem exists and whether further action by HCFA is warranted.

We appreciate being afforded the opportunity to submit comments on this GAO draft report.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Stephen P. Backhus, Assistant Director, (202) 512-7120 Donald J. Walthall, Senior Evaluator
Denver Regional Office	Donald C. Hahn, Evaluator-in-Charge Robert P. Pickering, Senior Evaluator Cheryl A. Brand, Staff Evaluator Pamela K. Tumler, Reports Analyst